Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
BERKSHIRE HATHAWAY HOMESTATE INC

MFDR Tracking Number
M4-14-0479-01

Carrier's Austin Representative
Box Number 06

MFDR Date Received
OCTOBER 10, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient has authorization for physical therapy and also for the work conditioning program. I have tried several time to get aqua paid in full without any success. Office visits are recommended as determined to be medically necessary. Medical Necessity for office visit in conjunction with work status form 73. Carrier shall not withdraw a preauthorization or concurrent review approval once issued."

Amount in Dispute: $3,813.71

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In regard to the dates of service, 1/16/13…. and 4/5/13, we have paid a total of $455.60 and agree to pay an additional $885.41. Based on the bills that we have received, there appears to be a duplicate listing of the date of service, 1/23/13 paycode 07113 for the charge of $278.00. We also have no evidence of every receiving a bill for date of service 4/23/13. A Plan Language Notice (PLN) 11 was filed on 2/6/13 limiting the extent of injury to lumbosacral contusion. A designated doctor (DD) exam took place on 3/8/13. The DD agreed that the extent of injury was limited to a lumbosacral contusion only. The services for dates of service 5/20/13 through 8/21/13 were denied based on the extent of injury dispute."

Response Submitted by: Berkshire Hathaway Homestate Companies

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 16, 2013 through April 5, 2013	Physical Therapy Services and Team Conference	$1,619.01	$0.00
May 30, 2013	Duplicate Services (listed on page 3 of table) consisting of CPT Codes: 99213, 97545, 97546	$260.39	$0.00
April 23, 2013	Physical Therapy Evaluation	$67.58	$67.58
May 20, 2013 through May 30, 2013	Work Conditioning	$864.00	$864.00
May 21, 2013, May 30, 2013, June 4, 2013, June 25, 2013, August 6, 2013, August 13, 2013, and August 21, 2013	Office Visits	$814.73	$814.73

May 21, 2013, June 4, 2013, June 14, 2013, June 25, 2013, and August 6, 2013	Work Status Report	$75.00	$30.00
June 28, 2013	Team Conference	$113.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.240 sets out the procedures for the Insurance Carrier Medical Payments and Denials.
3. 28 Texas Administrative Code §134.203 sets out the payment policies for Professional Services.
4. 28 Texas Administrative Code §134.204 sets out payment policies for Workers' Compensation Specific Services.
5. 28 Texas Administrative Code §129.5 sets out the guidelines for Work Status Reports.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 170 – Payment is denied when performed/bill by this type of provider.
   - D6 – The procedure is not allowed for this type of provider.
   - QT – A procedure has been billed which is out of the scope of practice for this provider.
   - W1 – Workers Compensation State Fee Schedule Adjustment.

Issues

1. Did the request received payment for dates of service January 16, 2013 through April 5, 2013?
2. Was date of service May 30, 2013 listed twice on the table of disputed services?
3. Was date of service April 23, 2013 reviewed by the respondent?
4. Were dates of service May 20, 2013 through August 21, 2013 denied based on extent of injury? Are these dates of service eligible for review and reimbursement?
5. Is the requestor entitled to reimbursement?

Findings

1. On August 6, 2015 the requestor's agent was contacted, by telephone, in regards to payments made by the respondent for dates of service January 16, 2013 through April 5, 2013. The requestor's agent, Tracy, responded that these dates of service have been paid and no longer in dispute. Therefore, Medical Fee Dispute Resolution will not review these dates of service.
2. Review of the disputed services finds that date of service May 30, 2013 was duplicated on page 2 and page 3 of the table. Services duplicated were CPT Codes 99213, 97545 and 97546. Therefore, the duplicate date of service on page 3 of the table will not be reviewed.
3. The requestor billed CPT Code 97002, Physical Therapy Evaluation, on April 23, 2013. The respondent states in their position statement that they "have no evidence of ever receiving a bill for the date of service 4/23/13." Review of the CMS-1500 finds that this code was billed with the date of service listed as April 23, 2013 with another CPT Code with a date of service April 25, 2013. Therefore, CPT Code 97002 is eligible for review in accordance with 28 Texas Administrative Code §134.204. This particular code was denied using denial codes 170 – "Payment is denied when performed/bill by this type of provider"; D6 – "The procedure is not allowed for this type of provider"; QT – "A procedure has been billed which is out of the scope of practice for this provider"; and W1 – "Workers Compensation State Fee Schedule Adjustment." Review of the documentation submitted by the respondent finds insufficient documentation to support the denial reasons. Therefore, in accordance with 28 Texas Administrative Code §134.203 reimbursement in the amount of $67.58 is recommended.
4. According the respondents position statement, the insurance carrier denied dates of service May 20, 2013 through August 21, 2013 based on an extent of injury. 28 Texas Administrative Code §133.240(e)(1), (2)(C) and (g) addressed actions that the insurance carrier was required to take, during the medical billing process, when the insurance carrier determined that the medical service was not related to the compensable injury. Those provisions, in pertinent parts, specified that the explanation of benefits shall be sent to: (1) the health

care provider when the insurance carrier makes payment or denies payment on a medical bill; and (2) the injured employee when payment is denied because the health care was: (C) unrelated to the compensable injury §124.2 of this title…(g) An insurance carrier shall have filed, or shall concurrently file, the applicable notice required by Labor Code §409.021, and §§124.2 and 124.3 of tthis title… If the insurance carrier reduces or denies payment for health care provided based solely on the insurance carrier's belief that: … (3) the condition for which the health care was provided was not related to the compensable injury.

The paper form of an explanation of benefits under subsection (e) of this section, §133.250 of this title (relating to Reconsideration for Payment of Medical Bills), or §133.260 of this title (relating to Refunds) shall include the following elements: (1) division claim number, if known; (2) insurance carrier claim number; (3) injured employee's name;(4) last four digits of injured employee's social security number; (5) date of injury; (6) health care provider's name and address; (7) health care provider's federal tax ID or national provider identifier if the health care provider's federal tax ID is the same as the health care provider's social security number; (8) patient control number if included on the submitted medical bill; (9) insurance carrier's name and address; (10) insurance carrier control number; (11) date of bill review/refund request; (12) diagnosis code(s); (13) name and address of company performing bill review;(14) name and telephone number of bill review contact; (15) workers' compensation health care network name (if applicable); (16) pharmacy, durable medical equipment, or home health care services informal or voluntary network name (if applicable) pursuant to Labor Code §408.0281 and §408.0284; (17) health care service information for each billed health care service, to include: (A) date of service; (B) the CPT, HCPCS, NDC, or other applicable product or service code;(C) CPT, HCPCS, NDC, or other applicable product or service code description;(D) amount charged;(E) unit(s) of service;(F) amount paid;(G) adjustment reason code that conforms to the standards described in §133.500 and §133.501 of this title if total amount paid does not equal total amount charged;(H) explanation of the reason for reduction/denial if the adjustment reason code was included under subparagraph (G) of this paragraph and if applicable… Review of the documentation submitted by the requestor finds that the insurance carrier did not submit any EOBs and that the format used by the insurance carrier did not include many of the elements required. Therefore reimbursement for the Work Conditioning Program, Office Visits, Work Status Reports and a Team Conference will be reviewed in accordance with applicable fee guidelines.

- CPT Code 97545-WC – Dates of Service: May 20, 2013 through May 30, 2013. In accordance with 28 Texas Administrative Code §134.204(h)(1)(B): If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. (2)(A): The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC."… (B) reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. Reimbursement in the amount of $345.60 (6 Units x $72.00 x 80% = $345.60) is recommended.
- CPT Code 97546-WC – Dates of Service: May 20, 2013 through May 30, 2013. In accordance with 28 Texas Administrative Code §134.204(h)(1)(B): If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR. (2)(A): The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WC." Each additional hour shall be billed using CPT Code 97546 with modifier "WC."… (B) reimbursement shall be $36 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. Review of the documentation submitted supports reimbursement in the amount of $518.40 (18 Units x $36.00 = $648.00 x 80%).
- CPT Code 99213 – Dates of Service: May 21, 2013 through August 21, 2013. In accordance with 28 Texas Administrative Code §134.203(c)(1) review of the submitted documentation supports reimbursement in the amount of $814.73 ((55.3 ÷ 34.023) x $71.61 x 7 units).
- CPT Code 99080-73 – Dates of Service: May 21, 2013 through August 21, 2013. In accordance with 28 Texas Administrative Code §129.5(d) the doctor shall file the Work Status Report: (1) after the initial examination of the employee, regardless of the employee's work status; (2) when the employee experiences a change in work status or a substantial change in activity restrictions. Review of the Work Status reports finds:
    - Review of the Work Status Report for May 21, 2013 meets the requirement of the rule; therefore, $15.00 is recommended.
    - Review of the Work Status Report for June 4, 2013 finds that there is no change in work status nor is there a substantial change in activity restrictions. Reimbursement is not recommended.

- Review of the Work Status Report for June 25, 2013 finds that there is no change in work status nor is there a substantial change in activity restrictions. Reimbursement is not recommended.
- Review of the Work Status Report for August 6, 2013 finds there is no change in work status; however, there is a substantial change in activity restrictions; therefore, $15.00 is recommended.
- Review of the Work Status Report for August 21, 2013 finds that there is no change in work status nor is there a substantial change in activity restrictions. Reimbursement is not recommended.

Total Reimbursement for the Work Status Reports is $30.00

- CPT Code 99361 – Date of Service: June 28, 2013. In accordance with 28 Texas Administrative Code §134.204(e)(4): Case management services require the treating doctor to submit documentation that identifies any HCP that contribute to the case management activity. Case management services shall be billed and reimbursed as follows: (A)(i) Reimbursement to the treating doctor shall be $113. Modifier "W1" shall be added. Review of the documentation finds that the treating doctor did not sign the team conference; therefore reimbursement is not recommended.

5. Review of the submitted documentation finds that reimbursement is due for some services.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,776.33.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,776.33 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 8, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.